



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SIERRA MEDICAL CENTER
1625 MEDICAL CENTER DRIVE
EL PASO, TX 79902

DWC Claim #:

Injured Employee:

Date of Injury:

Employer Name:

Insurance Carrier #:

Respondent Name

TPCIGA FOR UNITED PACIFIC INSU

Carrier's Austin Representative Box

50

MFDR Tracking Number

M4-07-4041-01

MFDR Date Received

MARCH 05, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the Table of Disputed Services: "Stop-Loss."

Amount in Dispute: \$54,790.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated April 9, 2007: "In conclusion, Provider has not met its burden of proof to establish that its billed charges are usual and customary, as that term has been defined our that TPCIGA's other audit reductions for unbundling, unidentified/incomplete charges, and error is incorrect. Provider has already been reimbursed at 75% of the total audited charges. Therefore, Provider is not entitled to any additional reimbursement ...TPCIGA has already reimbursed Provider at 75% of the total audited charges. Therefore, Provider is not entitled to additional reimbursement in this case."

Response Submitted by: Stone Loughlin & Swason, LLP

Respondent's Supplemental Position Summary Dated September 1, 2011: "Requestor is not entitled to reimbursement under the stop-loss exception to the former guideline because it has not demonstrated that the services it provided during this admission were unusually costly and unusually extensive. Requestor has not identified any specific services it contends were unusually extensive, it has not established the unusual cost of those services, and it has not established that it is not adequately reimbursed for those services under the standard per diem reimbursement method. For these reasons, reimbursement in this case should be pursuant to the standard per diem reimbursement plus carve-out method. Because TPCIGA has already paid Requestor in excess of this amount, it is entitled to a refund of the overpayment in the amount of \$39,428.85."

Response Submitted by: Stone Loughlin & Swason, LLP

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
September 04, 2006 through September 19, 2006	Inpatient Hospital Services	\$54,790.22	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 31 *Texas Register* 3561, effective May 2, 2006, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- W10 – No max allowable defined by fee guideline. Reimb made based on ins carrier f&r. Charges reduced to UCR to determine the total audited charges. Chgs exceed UCR for same similar geographic local based on med circumstances

Issues

1. Did the audited charges exceed \$40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?
5. Is the respondent entitled to an order or reimbursement or refund?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 *Texas Register* 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges **in this case** exceed \$40,000; whether the admission and disputed services **in this case** are unusually extensive; and whether the admission and disputed services **in this case** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection..." 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "...Audited charges are those charges which remain after a bill review by the insurance carrier has been performed..." Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$160,248.93. The division concludes that the total audited charges exceed \$40,000.
2. The requestor in its original position statement asserts that "Stop-Loss" In its position statement, the requestor presupposes that it is entitled to the stop loss method of payment because the audited charges exceed \$40,000. As noted above, the Third Court of Appeals in its November 13, 2008 rendered judgment to the contrary. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved...unusually extensive services." The requestor failed to discuss or demonstrate that the particulars of the admission in dispute constitute unusually extensive services; therefore, the division finds that the requestor did not meet 28 TAC §134.401(c)(6).
3. In regards to whether the services were unusually costly, the requestor in it's position statement does not address unusually costly. The third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must **demonstrate** that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor failed to discuss the particulars of the admission in dispute constitute unusually costly services; therefore, the division finds that the requestor failed to meet 28 TAC §134.401(c)(6).
4. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*. The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
 - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission..." The length of stay was fifteen days. The surgical per diem rate of \$1,118.00 multiplied by the length of stay of fifteen days results in an allowable amount of \$16,770.00.
 - 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than \$250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted documentation finds there is no itemized statement to determine the charges billed under revenue code 250. The requestor did not submit documentation to support what the cost to the hospital was for Thrombin USP TOP. For that reason, reimbursement for these items cannot be recommended.
 - 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399)." A review of the submitted hospital bill finds that the requestor billed \$1,349.00 for revenue code 390 – Blood Processing, and \$262.00 for revenue code 391 – Blood Administration. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue codes 390 and 391 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.
 - The division notes that 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." Review of the medical bill provided finds that the requestor billed items under revenue code 278; however the division was unable to determine what specific items were billed under that revenue code because no itemized statement was provided. The division was therefore unable to determine *if* the invoice found supported the cost of the implantables billed. For that reason, no additional reimbursement is recommended.

The division concludes that the total allowable for this admission is \$16,770.00. The respondent issued payment in the amount of \$58,822.35. Based upon the documentation submitted, no additional reimbursement can be

recommended.

5. In its response to the request for medical fee dispute resolution, the insurance carrier and respondent in this dispute requested "Requestor is not entitled to reimbursement under the stop-loss exception to the former guideline because it has not demonstrated that the services it provided during this admission were unusually costly and unusually extensive. Requestor has not identified any specific services it contends were unusually extensive, it has not established the unusual cost of those services, and it has not established that it is not adequately reimbursed for those services under the standard per diem reimbursement method. For these reasons, reimbursement in this case should be pursuant to the standard per diem reimbursement plus carve-out method. Because TPCIGA has already paid Requestor in excess of this amount, it is entitled to a refund of the overpayment in the amount of \$39,428.85." Texas Labor Code §408.0271 states, in pertinent part:

- (a) If the health care services provided to an injured employee are determined by the carrier to be **inappropriate** [emphasis added], the insurance carrier shall:
- (1) notify the health care provider **in writing** of the carrier's decision; and
 - (2) demand a refund by the health care provider of the **portion of payment** [emphasis added] on the claim that was received by the health care provider for the inappropriate services."
- Review of the documentation submitted finds that the respondent has not identified the "inappropriate" services, nor has it demonstrated the health care provider was notified in writing of its demand for a specific (dollar amount) refund prior to the medical fee dispute being filed.

Furthermore, applicable 28 TAC §133.260, 31 *Texas Register* 3544, effective May 2, 2006, provided, in pertinent part, that:

- (b) An insurance carrier shall request a refund within 240 days from the date of service or 30 days from completion of an audit performed in accordance with §133.230 (relating to Insurance Carrier Audit of a Medical Bill), whichever is later, when it determines that inappropriate health care was previously reimbursed, or when an overpayment was made for health care provided.
- (c) The insurance carrier shall submit the refund request to the health care provider in an explanation of benefits in the form and manner prescribed by the Division.

Review of the documentation provided by the respondent finds that the insurance carrier did not present a refund request to the health care provider within the time-frame specified, nor did the carrier submit any refund request to the health care provider in an explanation of benefits as required. The division concludes that the insurance carrier has not met the requirements of either Texas Labor Code §408.0271, nor has it met the requirements of applicable 28 TAC §133.260. For those reasons, the respondent's request for an order of reimbursement is not proper, and is not supported. An order of reimbursement for the respondent is therefore not recommended

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to discuss and demonstrate that the disputed inpatient hospital admission involved unusually extensive, and unusually costly services. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount*, and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	10/30/12 _____ Date
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_____ Signature	_____ Medical Fee Dispute Resolution	10/30/12 _____ Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.